Psychopharmacology FOR Dummies

Legislative Battles Over Prescription and Hospital Privileges for Psychologists

By Steven A. Ornish, MD

Psychologists' relentless legislative attempts to gain prescribing rights in the state of California and other states is medicine's Hydra: that multi-headed mythological beast whereby you lop off one head and two grow back. Senate Bill 1427, the Psychology Licensing Law, giving psychologists the right to prescribe drugs for specific psychiatric disorders, went down in defeat this year, this time. Psychologists' prescription-privilege legislation has been introduced in innumerable states and has passed in two states and one territory: New Mexico, Louisiana, and Guam.

In 1990, in *California Association of Psychology Providers v. Rank*, the Supreme Court of California ruled that psychologists could have primary responsibility for patient care in a hospital. Writes the sharply divided majority: "Such disputes over the competence of the professions must be decided by the Legislature, not the courts …we conclude that under California law a hospital that admits clinical psychologists to its staff may permit such psychologists to take primary responsibility for the admission, diagnosis, treatment, and discharge of their patients." Since this ruling, the battle has returned to state legislative and regulatory fronts.

Psychologists' latest strategy in California is to propose changes in state regulations granting hospital privileges permitting "attending" psychologists to oversee patient care on inpatient psychiatric units, hospitals, skilled nursing facilities, intermediate care facilities, chemical dependency hospitals, and correctional facilities without physician supervision. The California Department of Public Health has proposed regulations that grant medical decision-making authority and responsibility to hospital-based psychologists. The regulations would allow psychologists to direct overall care without physician supervision, including the authority to admit, discharge, write orders, perform consultations, and order seclusion and restraint. Essentially, psychologists would be given equal footing as physicians and permitted to function as psychiatrists on psychiatric units and in other institutions and facilities without the years of requisite medical and residency training that psychiatrists undergo.

What is driving this movement by psychologists is primarily economics: an oversupply of doctoral-level psychotherapists; a decrease in reimbursement for psychotherapy with preferential reimbursement for medication monitoring; and a concurrent increase in the demand for less-costly mental health services (1). As psychiatric treatments have become more scientifically and biologically based, psychologists are feeling increasingly squeezed in our managed-care era and want to expand their scope of practice into areas that currently fall within the purview of medicine.

An additional driving force is PhRMA, which has an economic interest in expanding the number of professionals who can prescribe psychotropic medications. For example, the cost of the medication alone for treating one patient for one year with one of the newer antidepressants such as Cymbalta is $1,512 (assuming $4.20/pill) (2). Psychologists with prescribing privileges would provide a greatly expanded pool of prescribers of psychotropic medications for the pharmaceutical industry and likely an increased pool of patients receiving their products, thus increasing profits.

Since July 2002, New Mexico psychologists have been permitted to gain prescribing privileges, after completing 450 hours in neuroscience, pharmacology, psychopharmacology, physiology, "laboratory assessment," and clinical pharmacology. Psychologists in New Mexico must also spend at least 400 hours treating at least 100 patients with mental disorders under the close supervision of a psychiatrist or other physician. The supervising "other physician" can be a family physician, or from any specialty for that matter. Dr. Joel Yager, professor of psychiatry at the University of New Mexico, described this training as "psychopharmacology for dummies" (3). In 2004, Louisiana became the second state authorizing psychologists to prescribe psychotropic medications.

In contrast to the 450 hours of requisite didactic study and 400 hours "treating" patients by psychologists seeking prescribing privileges, to receive a doctor of medicine (MD) degree in the state of California requires a minimum of 4,000 hours of study learning biochemistry, physiology, pathology, neurology, internal medicine, general pharmacology, etc. The average number of hours spent by a psychiatry resident learning patient evaluation and treatment selection, psychopharmacology, adult psychopathology, behavioral science, social psychiatry, psychosocial therapies, differential diagnosis, growth, and development is 11,520 hours (4). Therefore, a board-certified psychiatrist has more than 15,000 hours of supervised medical school and psychiatric residency training, or fifteen times the hours required by a psychologist attempting to qualify for prescribing privileges in New Mexico.

The late Maurice Rappaport, MD, PhD, both a psychiatrist and a psychologist, and a past president of the California Psychiatric Association, was particularly outspoken over this issue:

"What the psychologists are asking for is the right to practice medicine without going to medical school — that's as dangerous as it is ludicrous. … Psychologists are trying to achieve through legislation what they don't achieve through education"(5).

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In 1991, the Military Health System (MHS) of the Department of Defense (DoD) instituted the Psychopharmacology Demonstration Project, which was

designed to train and use military psychologists to prescribe psychotropic medications. Ten psychologists were trained, and in 1997, after spending $6.1 million, the DoD canned the program as a failure after the General Accounting Office (GAO), the congressional "watchdog" agency, performed a detailed audit and concluded that the average yearly cost of using a psychologist to prescribe medications in contrast to treating patients with the combination of psychiatrists and psychologists in their traditional roles was 7 percent higher and not cost-effective. From the GAO report:

"Training psychologists to prescribe medication is not adequately justified because MHSS has not demonstrated a need for them, the cost is substantial, and the benefits are uncertain" (6).

Moreover, there was reduced legal exposure by these psychologists (or supervising psychiatrists), since under the Feres Doctrine active duty military personnel are immune from lawsuits for injuries that they have caused to other military personnel by their negligence, gross or otherwise. Dependents, however, can still sue the federal government if subject to medical malpractice. While psychologists often disingenuously refer to this experiment as a success, the DoD cancelled the program, and there are no psychologists prescribing in the Navy today.

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Despite the failed and defunct DoD Psychopharmacology Demonstration Project, psychologists working within the California Department of Corrections have proposed a similar pilot project for prescription training. Interestingly, in California, the Office of Statewide Health Planning and Development has the authority to waive scope of practice laws for "innovative pilot projects."

Why not give psychologists prescribing privileges? After all, how much skill does it take to write a prescription for Lexapro for a depressed patient? And why stop there? If the psychologist's patient complains of a productive cough during his or her therapy session, why should the psychologist not be permitted to write a prescription for some Biaxin or a Z-pak — that's a no-brainer. Headaches are a common psychosomatic symptom presenting to psychologists; how much training is required to prescribe a few Vicodin or Percocet to relieve the somatic suffering of their patient in front of them?

The erroneous belief by some psychologists that practicing psychopharmacology is relatively simple may stem from their observing a competent physician prescribe psychotropic medications to an uncomplicated patient. One's ability to recognize the complexities of a patient, and competently manage his or her psychotropic medications and adverse reactions, is directly proportional to the depth and breadth of one's medical education and experience, and flows from the deep culture of medicine. Hypothetically, a psychologist could

be trained to do an uncomplicated appendectomy after 450 hours of training, but it is inconceivable that the state of California would grant a psychologist surgical privileges. Nor would we permit airline mechanics to fly commercial jets after a crash course (no pun intended) to save costs and serve underserved areas.

The issue at hand is not whether a nonphysician can be trained to write for a standard dose of a psychotropic medication in

an uncomplicated patient. In fact, they can and physician nurse practitioners and assistants do it routinely throughout the country, but only after years of medical training and always under the supervision of a physician. How can anyone reasonably believe that psychologists, with absolutely no medical training whatsoever, not even knowing how to take a blood pressure, could adequately prescribe medications without any physician supervision?

The "deep structures" of psychiatry and psychology are also quite different. Although both disciplines deal with the psyche, psychiatry's roots are firmly planted in the healing arts of the Hippocratic tradition dating back to ancient Greece in 400 BCE. Psychology, in contrast, has its roots in the clinic established by Lightner Witmer at the University of Pennsylvania in 1896, whose work involved treating intellectually impaired children with remedial education (7). Since psychologists are trained in human development and behavior, and not medicine, their approach to psychiatric diagnoses is psychosocial and symptom-based, not medical. As Hippocrates wisely stated, "Life is short, science is long; opportunity is elusive, experiment is dangerous, judgment is difficult"(8).

It is naive to suggest that a didactic crash course in pharmacology with 10 weeks' equivalent of supervised patient care will safely supplant what otherwise requires eight years of intensive study in medical school and residency, especially in the absence of any grounding in the basic medical sciences. A study by Robert Sbordone, PhD, found that clinical psychologists failed to recognize that a patient required a referral to a neurologist 50 percent of the time when presented with clinical vignettes of patients with obvious neurologic disease (9). If psychologists can purportedly safely and competently prescribe psychotropic medications after remedial course work and limited supervision by a nonpsychiatrist, why not be more egalitarian and permit social workers, psychiatric nurses, marriage and family counselors to do the same?

Psychotropic medications are potent agents, have effects not only on the brain but also on multi-organ systems, have potential serious side-effects and adverse reactions, and can cause disability and death, which is why they are not sold over-the-counter. Making correct diagnoses and recognizing complex and potentially life-threatening adverse reactions of psychotropic medications requires a deep, multidimensional, in-depth understanding not only of pharmacology, but also of physiology, internal medicine, pathology, neurology, drug-drug interactions, mitochondrial enzyme pathways, receptor functionality, and biovariability. Psychologists simply do not have the requisite training to formulate medical differential diagnoses and rule out medical causes of psychiatric symptoms. Nor do psychologists have the necessary medical training to recognize and manage complex adverse reactions from psychotropic medications such as prodromal neuroleptic syndrome presenting as a low-grade fever; lithium-induced nephrogenic diabetes insipidus presenting as polyuria; delirium secondary to low-dose benzodiazepines in the elderly with a superimposed urinary tract infection; the serotonergic syndrome from SSRIs presenting as fever and confusion; and the metabolic syndrome presenting with secondary diabetes mellitus from atypical antipsychotics — to name a few.

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In the state of California, medical malpractice or medical negligence occurs when a doctor or other healthcare provider breaches his or her duty to perform treatment to a patient in accordance with the "standard of care." The "standard of care" in California requires that a healthcare provider exercise adequate skill, knowledge, and care ordinarily possessed and exercised by other members of the profession acting under similar circumstances. Should psychologists be granted prescription privileges, what does this mean for the standard of care? Will there be a double-standard of care: one for physicians and one for psychologists?

Should psychologists prevail in California and other parts of the country with this dangerous experiment now being performed in New Mexico, Louisiana, and Guam, the result will be harm to patients and increased litigation. Psychologists with prescribing privileges will diminish the hard-earned professional identity not only of psychiatrists, but of all physicians, because the public will not discern the blurred differences among "doctors." The power granted to physicians by the state to prescribe is not a "right," it is a privilege earned by the top-of-the-class students who were carefully selected to undergo an average of eight years of intensive medical and residency training in institutions with high, uniform standards carefully monitored for quality.

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